2009 DRAFTING REQUEST

Assembly Substitute Amendment (ASA-AB207)

Received: **12/28/2009**

Received By: **tdodge**

Wanted: **01/06/2010**

Identical to LRB:

For: **Chuck Benedict (608) 266-9967**

By/Representing: **Tara Vasby**

This file may be shown to any legislator: **NO**

Drafter: **tdodge**

May Contact:

Addl. Drafters:

Subject: **Health - miscellaneous**

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Benedict@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Changes to facility use charge disclosure requirements

Instructions:

See attached. Based on ASA1, AA1 to ASA1, and additional changes via email.

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	tdodge 01/05/2010	csicilia 01/06/2010		_____ _____			
/1			rschluet 01/06/2010	_____ _____	cduerst 01/06/2010	cduerst 01/06/2010	
/2	tdodge 01/27/2010	csicilia 02/03/2010	phenry 02/03/2010	_____ _____	sbasford 02/03/2010	sbasford 02/03/2010	

FE Sent For:

<END>

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/1		1/2 gjs 2/3 10	rschluet 01/06/2010	_____ _____	cduerst 01/06/2010	cduerst 01/06/2010	

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/?	tdodge	/1 gjs 1/6 10	1/6	1/6 ph 1/6			

FE Sent For:

<END>

Dodge, Tamara

From: Vasby, Tara
Sent: Tuesday, December 29, 2009 10:41 AM
To: Dodge, Tamara
Subject: RE: Draft - Request for Sub 2 to AB207

On point two, I think your wording is fine. I agree with you.

On point one - all health care facilities and their billing offices have to use a universal health care billing code system - which I believe is Federally managed. But let me see if I can identify exactly what it is called. Dick Sweet might know if he's around this week.

Thanks!
Tara Vasby

From: Dodge, Tamara
Sent: Tuesday, December 29, 2009 10:04 AM
To: Vasby, Tara
Subject: RE: Draft - Request for Sub 2 to AB207

Tara,

I have some questions about the new changes for the Sub 2. First, do all providers use revenue codes? I hadn't heard of them before. Who uses them (internal billing, providers, etc.) and do they appear on the bill that the patient sees? I am concerned about just using the term "revenue code" with no other reference to where the code is or what it is used for. Note that I am writing the statute from the perspective of what the patient sees not what the provider does.

Second, with the recommended changes, the intro to sub. (2) and the paragraphs do not seem to work together. The intro refers to the provider itemizing a charge, which means to me that a separate charge may appear on the same bill as the other charges. The paragraphs now refer to getting two separate bills not two separate charges. What if the provider bills the provider charge and the clinic charge on the same bill? I want to make sure that the bill covers all the diverse billing systems and methods used by all health care providers, presuming that is what you want to do with this bill. Could I still refer to the separate charge for clinic use and say "or may receive more than one bill for the office visit." This would cover instances where the charge for clinic use comes as a separate item and when it comes on a separate bill.

Thanks.
Tami

Tamara J. Dodge
Attorney
Wisconsin Legislative Reference Bureau
P.O. Box 2037
Madison, WI 53701-2037
(608) 267 - 7380
tamara.dodge@legis.wisconsin.gov

From: Vasby, Tara
Sent: Monday, December 28, 2009 10:27 AM
To: Dodge, Tamara
Subject: Draft - Request for Sub 2 to AB207

Tamara,
We are going to need a substitute amendment 2 to AB207. Based on Sub 1, plus AA1 to ASA1 but with the following changes. The public hearing on the issue is tomorrow, but I totally understand that it is next to impossible to have this ready by then. We do intend to hold an executive session on the

bill on January 12, 2010 and would like the sub 2 to be ready by January 6th if that's possible. I need to take it around to committee members. Thanks much!
Tara Vasby
Leg. Assistant
Rep. Chuck Benedict

1 - Replace all references to "facility use charge" with "Charge for Clinic services". This is the preferred terminology of the Hospitals.

2 - Page 3, lines 17-25 of Sub 1 - replace with something similar to:

If a health care facility or health care provider itemizes a charge for clinic services provided during a patient's visit with a health care practicioner, as defined by the use of a revenue code inidicating clinic services (NOTE, they are currently 510 – 519) the health care facility or health care provider shall do all of the following:

A - If the appointment is made in person or over the telephone, at the time the appointment is made notify the patient orally that the patient may receive more than one bill for the clinic visit covering services related to the clinic and services provided by the health care practicioner, and that the patient should check with his or her insurer to determine whether the insurer covers the charges.

B - If the appointment is made by the patient electronically, then within 24 hours the paitent must be notified through written or electronic correspondence that the patient may receive more than one bill for the clinic visit covering services related to the clinic and services provided by the health care practicioner, and that the patient should check with his or her insurer to determine whether the insurer covers the charges.

C - Upon the request of the patient and before the end of the next business day after the day on which the appointment is made, provide the patient with a good faith estimate of the charge for clinic services.

3 - Delete starting from page 3, line 25 through page 4, lines 1-4. So, the sentence reads, "provide a patient with a good faith estimate of the facility use charge."

4 - We have also been trying to address the issue of "subsequent appointments". For example, you make your initial appointment and they say, come back in 4 weeks and you leave the office and make an appointment at the desk that day.

Language offered by Dick Sweet on "subsequent appointments"

Page 4, after line 6 insert:

(2m) Subsection (2)(a) and (b) do not apply to a patient office visit if all of the following conditions are met:

(a) The health care facility or health care provider has [previously] [within the 90 days prior to the appointment] provided the patient with the required notification and good faith estimate under sub. (2)(a) and (b) for an office visit.

(b) The current office visit is for the same services as the services provided in the office visit under par. (a).

The 2 bracketed items are options for dealing with prior notice and estimates.

Our office feels that the 90 days is appropriate, so this language is fine.

Dodge, Tamara

From: Vasby, Tara
Sent: Tuesday, December 29, 2009 10:46 AM
To: Dodge, Tamara
Subject: RE: Draft - Request for Sub 2 to AB207

Here is the title of the code system - Healthcare Common procedure Coding System

I realize this link is Wikipedia, but based on my quick Google search, this is the most comprehensive explanation:
http://en.wikipedia.org/wiki/Healthcare_Common_Procedure_Coding_System

So, perhaps it is referred to in statute as Healthcare Common Procedure Coding System? Is there any reference to it in Medicaid related statue?

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Sent: Tuesday, December 29, 2009 10:04 AM
To: Vasby, Tara
Subject: RE: Draft - Request for Sub 2 to AB207

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0220

State of Wisconsin
2009 – 2010 LEGISLATURE

In: 1/5/10 Due 1/6/10

LRBs0144/1
TJD:cjs:ph
T
stays

ASSEMBLY SUBSTITUTE AMENDMENT 1,

TO 2009 ASSEMBLY BILL 207

d-note

fullmisc SA

October 20, 2009 – Offered by Representative BENEDICT.

Gen Cat

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and ***to create*** 146.97, 609.895 and 632.792 of the statutes; **relating to:** requiring that patients be informed of any health care facility use charge and that the charge be identified and requiring disclosure of insurance coverage of facility use charge.

charge for clinic services

a charge for clinic services

Ins A-1

Analysis by the Legislative Reference Bureau

This substitute amendment requires a health care facility or health care provider that itemizes a charge for use of the facility to notify a patient, orally at the time the appointment is made, that it will impose the facility use charge. Before the end of the next business day after the appointment is made, the health care facility or health care provider must provide the patient with a good faith estimate of the facility use charge. The health care facility or health care provider on any bill imposing the charge, must identify the facility use charge as a "facility fee" but may charge a facility use charge different from the amount given in the good faith estimate.

Beginning on January 1, 2011, this substitute amendment also requires health insurance policies and self–insured governmental and school district health plans to disclose in a policy, plan, or certificate of coverage all of the following regarding the facility use charge: whether the policy or plan covers a health care facility use charge

charge for clinic services

Charge for clinic services

and to what extent the charge is covered, whether the policy or plan imposes limitations on the coverage of the facility use charge, and whether a patient's payment of all or part of the facility use charge counts toward any deductible under the policy or plan. The disclosure requirement applies to individual and group health insurance policies, including limited service health organizations, preferred provider plans, defined network plans, and cooperative sickness care associations; to health care plans, including a self–insured plan, offered by the state to its employees; and to self–insured health plans of a city, town, village, county, or school district.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.792, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.885, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 2. 40.51 (8m) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.792, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, and 632.895 (11) to (17).

SECTION 3. 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

66.0137 **(4)** SELF–INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis,

the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.792, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 4. 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.792, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 5. 146.97 of the statutes is created to read:

146.97 Health care facility use charges. (1) In this section:

(a) "Clinic" means a place that is used primarily ~~for the provision of~~ services of a health care provider.

(b) "Health care facility" has the meaning given in s. 146.997 (1) (c) and includes a clinic and an ambulatory surgery center, as defined in s. 153.01 (1g).

(c) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (k).

(2) If a health care facility or a health care provider itemizes a billing charge for ~~use of the health care facility during a patient's office visit with a health care provider~~, the health care facility or health care provider shall do all of the following:

(a) At the time the appointment is made, notify the patient orally that the health care facility use charge will be imposed and that the patient should check with his or her insurer to determine whether the insurer covers that charge.

(b) Before the end of the next business day after the day on which the appointment is made, provide the patient with a good faith estimate of the facility use charge either as a specific dollar amount or as a dollar range that includes at least

80 percent of the health care facility's or health care provider's facility use charges over a 12–month period that ended within 6 months before the date of the estimate. An estimate that is placed in the mail before the end of the next business day is provided within the time required under this paragraph.

(c) Identify in any bill for the office visit the health care facility use charge as a "facility fee."

(3) The facility or the provider may charge to the patient an actual facility use charge that is different from the good faith estimate of the facility use charge provided under sub. (2) (b).

SECTION 6. 185.981 (4t) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.792, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.895 (10) to (17), and 632.897 (10) and chs. 149 and 155.

SECTION 7. 185.983 (1) (intro.) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.792, 632.795, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.895 (5) and (9) to (17), 632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 8. 609.895 of the statutes is created to read:

609.895 Disclosure of ~~facility use charge~~ coverage. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.792.

SECTION 9. 632.792 of the statutes is created to read:

632.792 Disclosure of ~~facility use charge~~ coverage. (1) DEFINITIONS. In this section:

~~(a)~~ "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

~~(b) "Health care facility" has the meaning given in s. 146.97 (1) (b).~~

~~(c)~~ "~~Health care facility use charge~~" means an itemized billing charge by a health care facility or health care provider for use of the health care facility during a patient's office visit with a health care provider.

~~(d) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (k).~~

~~(e)~~ "Self-insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) REQUIRED DISCLOSURE. Every disability insurance policy and every self-insured health plan shall disclose of all of the following in any policy, plan, or certificate of coverage:

(a) Whether the policy or plan covers a ~~health care facility use~~ charge.

(b) The extent of, and limitations on, coverage of a ~~health care facility use~~ charge.

(c) Whether a patient's payment for all or part of a ~~health care facility use~~ charge counts toward satisfying any deductible amount under the policy or plan.

SECTION 10. Initial applicability.

(1) The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.895, and 632.792 of the statutes first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and governmental or school district self–insured health plans that are established, extended, modified, or renewed, on the effective date of this paragraph.

(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(c) Governmental or school district self–insured health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

SECTION 11. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.895, and 632.792 of the statutes and SECTION 10 of this act take effect on January 1, 2011.

(END)

D-note

INSERT A-1

This substitute amendment requires a health care facility or health care provider that itemizes a charge for clinic services to notify a patient that it may impose the charge for clinic services in addition to the charge for services provided by the health care provider during an office visit. The health care facility or health care provider must make the notification orally at the time the appointment is made if the patient makes the appointment in person or by telephone and electronically or in writing within 24 hours after the appointment is made if the patient makes the appointment electronically. Upon request of the patient, the health care facility or health care provider must provide the patient with a good faith estimate of the charge for clinic services before the end of the next business day after the day the patient makes the request for the estimate. On any bill imposing the charge, the health care facility or health care provider must identify the charge as a "charge for clinic services" but may charge an amount different from the amount given in a good faith estimate. A health care facility or health care provider is not required to make the notification that a charge for clinic services may be imposed if the health care facility or health care provider provided the notification for a previous office visit for the same services within 90 days before the appointment is made if the patient makes the appointment in person or over the telephone or within 90 days before the health care facility or health care provider receives the appointment request if the patient makes the appointment electronically.

INSERT 3-14

(b) "Charge for clinic services" means a billing charge by a health care facility or a health care provider for use of the health care facility during a patient's office visit with a health care provider indicated by a billing code for clinic services under the Healthcare Common Procedure Coding System, as described in 45 CFR 162.1002.

INSERT 3-20

(a) 1. If a patient makes an appointment for an office visit in person or over the telephone, notify the patient orally at the time the appointment is made that the

patient may receive, in addition to a charge for the services provided by the health care provider during the office visit, a charge for clinic services, which may be on a separate bill, and advise that the patient check with his or her insurer to determine whether the insurer covers the charge.

2. If a patient makes an appointment for an office visit electronically, notify the patient electronically or in writing within 24 hours of the health care provider receiving the electronic appointment request that the patient may receive, in addition to a charge for the services provided by the health care provider during the office visit, a charge for clinic services, which may be on a separate bill, and advise that the patient check with his or her insurer to determine whether the insurer covers the charge.

INSERT 4-7

(3) The health care facility or health care provider is not required to provide the notification under sub. (2) (a) 1. or 2. for an office visit if the health care facility or health care provider provided the patient with the notification under sub. (2) (a) 1. or 2. for a previous office visit for the same services within one of the following periods:

(a) Ninety days before the appointment is made if the patient makes the appointment in person or over the telephone.

(b) Ninety days before the health care facility or health care provider receives the appointment request if the patient makes the appointment electronically.

(END)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBs0220/1dn
TJD:.../...
cjs

Date

To Tara Vasby:

Please review this substitute amendment to ensure it complies with your intent. This substitute amendment is based on Assembly Substitute Amendment 1 and the simple amendment to that substitute amendment. I have also incorporated the requested additional changes but have changed the wording in some places. Please note that the requested change regarding the revenue codes is incorporated in a definition of "charge for clinic services."

Please note that I also made an additional change to the paragraph requiring the good faith estimate. Since the good faith estimate is only required upon the patient's request, I attached the time limit for providing the good faith estimate to the making of the request instead of the making of the appointment. The patient may not request the estimate until more than one business day after the appointment is made, especially when the patient makes the appointment electronically and the health care facility has 24 hours to notify the patient that the charge for clinic services may be imposed. Using the patient's request as the trigger for the deadline solves this problem. Please let me know if you would like to return to previous language for this provision.

the

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Legislative Attorney
Phone: (608) 267-7380
E-mail: tamara.dodge@legis.wisconsin.gov

DRAFTER'S NOTE
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LEGISLATIVE REFERENCE BUREAU

LRBs0220/1dn
TJD:cjs:rs

January 6, 2010

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E-mail: tamara.dodge@legis.wisconsin.gov

Dodge, Tamara

From: Vasby, Tara
Sent: Wednesday, January 20, 2010 9:07 AM
To: Dodge, Tamara
Subject: Last changes to AB207

Tamara,
I think we are almost done with this now. Can I have the following changes incorporated into a Sub 3 (so we have a clean document to work from) and then before we send it to the chief clerk, I'd like a preliminary copy - so as to avoid a Sub 4!

Based on the language in Sub 2 -

Page 4 - line 11. End the sentence after "separate bill" and delete the remaining language of lines 11 and 12.

Page 4, line 20. We need to make a change to allow two business days instead of the next business day.

Page 5, line 6 and line 8 - change references from 90 days to 1 year.

Dick Sweet also made some notes that I've attached. Your thoughts?

> I noticed a couple of other issues regarding the sub. The first sub deleted some references to office visits, and the second sub puts some back in. Was that intended? I don't know that these appointments are all office visits; the term isn't defined in the sub.
>
> As I mentioned the other day, you may want to add back into the second sub the language from the first sub that says that if an estimate is put in the mail by the end of the next business day, this satisfies the requirement.

If you have any questions, please let me know. The end goal is to exec this bill on Feb 9th. Thanks much!

Tara Vasby
Leg. Assistant
Rep. Chuck Benedict

Dodge, Tamara

From: Vasby, Tara
Sent: Thursday, January 21, 2010 9:04 AM
To: Dodge, Tamara
Subject: AB207 - question on some language

Tamara,
First - I found the stripes for ASA2 that didn't get sent to the Chief Clerk so it hasn't been introduced. So, I can send those back to you and we can keep working on the Sub 2.

Second - there have been questions raised about the wording on page 5, Sub 3 relating to the recurring appointments. Children's Hospital and Dick Sweet have now interpretted the language to mean that annual notice must be given to patients who have recurring appointments - even if those appointments continue longer than 12 months (sub currently reads 90 days). Do you also read it that way?

The intent was to only verbally notify patients of the the facility fee at their first appointment and then if they had recurring appointments for the same thing over a period of time, they would not need to be notified again for that next appointment. Even if they had 18 monthly visits, they would only need to be told orally when they schedule the first one.

Dick Sweet suggested the following language, but I read it as not having to notify patients who are already getting written notification. Which creates an ugly loophole for other hospitals. Perhaps I am reading it wrong?

I would appreciate your insight.
Thanks!
Tara Vasby
Leg. Assistant
Rep. Chuck Benedict

(3m) The health care provider is not required to provide oral notification under sub. (2)(a)1. for an office visit that occurs after the period specified in sub. (3)(a) or (b) if the facility or provider if the provider did all of the following:

(a) Provided oral notification at least once for a previous office visit for the same services.

(b) Provided written notification of the information required under sub. (2)(a)1. for an office visit within the previous 12 months (90 days?) for the same services.

(c) Provided written notification of the information required under sub. (2)(a)1. for the current office visit for the same services.

Dodge, Tamara

From: Vasby, Tara
Sent: Monday, January 25, 2010 11:07 AM
To: Dodge, Tamara
Subject: RE: AB207 - recurring appointments

Tami,
Dick Sweet called and we talked about the language of "office visit". He suggested perhaps use "health care facility visit" since health care facility is already defined?

Tara Vasby
Rep. Benedict

Dodge, Tamara

From: Vasby, Tara
Sent: Tuesday, January 26, 2010 9:41 AM
To: Dodge, Tamara
Subject: FW: AB207 - recurring appointments

Tami,
After a few emails back and forth, the Hospitals are okay with Dick Sweet's suggestions (based on your language). They are in bold below. I've also attached the suggestion of Michelle Mettner of Children's Hospital for your reference.

Thanks for your work on this!

I've also got a small change to the Menu Labeling bill coming your way shortly.

Tara Vasby
Leg. Assistant
Rep. Chuck Benedict

From: Sweet, Richard
Sent: Monday, January 25, 2010 1:43 PM
To: 'Mettner, Michelle'; Melissa Duffy; Vasby, Tara; 'Paul Merline'
Subject: RE: AB207 - recurring appointments

Michelle, I'm assuming that you want to add to par. (b) that the required notice was given at some point in time prior to the 12-month period. Also, shouldn't par. (a) also include the requirement that the notice was given when the patient received the same services? How about something along the following lines:

(3) The health care facility or health care provider is not required to provide the notification under sub. (2)(a) 1. or 2. in either of the following situations:

(a) The facility or provider provided the patient with the notification under sub. (2)(a) 1. or 2. for an office visit for the same services within the previous 12 months.

(b) The facility or provider provided the patient with the notification under sub. (2)(a) 1. or 2. for an office visit for the same services before the previous 12 months and the patient has also received the same services within the previous 12 months.

Let me know if this is too complicated and maybe it can be pared down.

Dick Sweet
Senior Staff Attorney
Wisconsin Legislative Council
(608)266-2982
richard.sweet@legis.wisconsin.gov

From: Mettner, Michelle [mailto:MMettner@chw.org]
Sent: Monday, January 25, 2010 1:14 PM
To: Melissa Duffy; Vasby, Tara; 'Paul Merline'
Cc: Sweet, Richard
Subject: RE: AB207 - recurring appointments

Hi all: I agree that the language appears more confusing than the clarification sought, and I also very much appreciate that we are working on addressing Children's conern. It is not a hypothetical; a real issue for us, so I thank you.

Melissa's point is a fair one. I think we all agree that oral notification be given to all new patients and that if a patient has not been seen by the same health care facility/provider in 12 months, he/she be considered "new" and therefore receive oral notification again. Here is a simpler language suggestion for your consideration:

(3) The health care facility or health care provider is not required to provide the notification under sub. (2) (a) 1. or 2. for an office visit if in the prior twelve months from scheduling:

(a) the health care facility or health care provider provided notice to the patient under sub. (2) (a) 1. or 2. or

(b) the patient had been seen by the same health care facility or health care provider for the same condition.

This language still limits the fact that if the provider has not seen the patient in 12 months, oral notification at the time of scheduling is required. It also allows for the recurring appointments to be covered and not require redundant notification.

Michelle

Michelle I. Mettner
Vice President, Government Relations & Advocacy
Children's Hospital & Health System
(414) 266-5434 (direct)
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WED

State of Wisconsin
2009 - 2010 LEGISLATURE

LRBs0220/1 2
TJD:cjs:rs

In 1/27/10 soon

RMR

8 days

ASSEMBLY SUBSTITUTE AMENDMENT ,

TO 2009 ASSEMBLY BILL 207

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AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t) and 185.983 (1) (intro.); and ***to create*** 146.97, 609.895 and 632.792 of the statutes; **relating to:** requiring that patients be informed of any charge for clinic services and requiring disclosure of insurance coverage of a charge for clinic services.

a health care facility
a health care facility

Analysis by the Legislative Reference Bureau

This substitute amendment requires a health care facility or health care provider that itemizes a charge for clinic services to notify a patient that it may impose the charge for clinic services in addition to the charge for services provided by the health care provider during an office visit. The health care facility or health care provider must make the notification orally at the time the appointment is made if the patient makes the appointment in person or by telephone and electronically or in writing within 24 hours after the appointment is made if the patient makes the appointment electronically. Upon request of the patient, the health care facility or health care provider must provide the patient with a good faith estimate of the charge for clinic services before the end of the next business day after the day the patient makes the request for the estimate. On any bill imposing the charge, the health care facility or health care provider must identify the charge as a "charge for

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clinic services" but may charge an amount different from the amount given in a good faith estimate. A health care facility or health care provider is not required to make the notification that a charge for clinic services may be imposed if the health care facility or health care provider provided the notification for a previous office visit for the same services within 90 days before the appointment is made if the patient makes the appointment in person or over the telephone or within 90 days before the health care facility or health care provider receives the appointment request if the patient makes the appointment electronically.

Beginning on January 1, 2011, this substitute amendment also requires health insurance policies and self-insured governmental and school district health plans to disclose in a policy, plan, or certificate of coverage all of the following regarding the charge for clinic services: whether the policy or plan covers a charge for clinic services and to what extent the charge is covered, whether the policy or plan imposes limitations on the coverage of the charge for clinic services, and whether a patient's payment of all or part of the charge for clinic services counts toward any deductible under the policy or plan. The disclosure requirement applies to individual and group health insurance policies, including limited service health organizations, preferred provider plans, defined network plans, and cooperative sickness care associations; to health care plans, including a self-insured plan, offered by the state to its employees; and to self-insured health plans of a city, town, village, county, or school district.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.792, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.885, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 2. 40.51 (8m) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747,

632.748, 632.792, 632.83, 632.835, 632.85, 632.853, 632.855, 632.885, and 632.895 (11) to (17).

SECTION 3. 66.0137 (4) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.792, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 4. 120.13 (2) (g) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.792, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 5. 146.97 of the statutes is created to read:

health care facility

146.97 Charges for clinic services. (1) In this section:

(a) "Charge for clinic services" means a billing charge by a health care facility or a health care provider for use of the health care facility during a patient's office visit with a health care provider indicated by a billing code for clinic services under the Healthcare Common Procedure Coding System, as described in 45 CFR 162.1002.

(b) "Clinic" means a place that is used primarily for the provision of services of a health care provider.

(c) "Health care facility" has the meaning given in s. 146.997 (1) (c) and includes a clinic and an ambulatory surgery center, as defined in s. 153.01 (1g).

(d) "Health care provider" has the meaning given in s. 146.81 (1) (a) to (k).

(2) Except as provided in sub. (3), if a health care facility or a health care provider itemizes on a bill a charge for clinic services, the health care facility or health care provider shall do all of the following:

(a) 1. If a patient makes an appointment for an office visit in person or over the telephone, notify the patient orally at the time the appointment is made that the patient may receive, in addition to a charge for the services provided by the health care provider during the office visit, a charge for clinic services, which may be on a separate bill, and advise that the patient check with his or her insurer to determine whether the insurer covers the charge.

2. If a patient makes an appointment for an office visit electronically, notify the patient electronically or in writing within 24 hours of the health care provider receiving the electronic appointment request that the patient may receive, in addition to a charge for the services provided by the health care provider during the office visit, a charge for clinic services, which may be on a separate bill, and advise that the patient check with his or her insurer to determine whether the insurer covers the charge.

(b) Upon request of the patient and before the end of the next business day after the day on which the request is made, provide the patient with a good faith estimate of the charge for clinic services.

(c) Identify in any bill for the office visit the charge for clinic services as a "clinic service charge."

(3) The health care facility or health care provider is not required to provide the notification under sub. (2) (a) 1. or 2. for an office visit if the health care facility or health care provider provided the patient with the notification under sub. (2) (a) 1. or 2. for a previous office visit for the same services within one of the following periods:

(a) Ninety days before the appointment is made if the patient makes the appointment in person or over the telephone.

(b) Ninety days before the health care facility or health care provider receives the appointment request if the patient makes the appointment electronically.

(4) The facility or the provider may charge to the patient an actual charge for clinic services that is different from the good faith estimate of the charge for clinic services provided under sub. (2) (b).

SECTION 6. 185.981 (4t) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

185.981 **(4t)** A sickness care plan operated by a cooperative association is subject to ss. 252.14, 631.17, 631.89, 631.95, 632.72 (2), 632.745 to 632.749, 632.792, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.895 (10) to (17), and 632.897 (10) and chs. 149 and 155.

SECTION 7. 185.983 (1) (intro.) of the statutes, as affected by 2009 Wisconsin Act 28, is amended to read:

185.983 **(1)** (intro.) Every such voluntary nonprofit sickness care plan shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.67, 619.04, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.792, 632.795, 632.85, 632.853, 632.855, 632.87 (2m), (3), (4), (5), and (6), 632.885, 632.895 (5) and (9) to (17),

632.896, and 632.897 (10) and chs. 609, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 8. 609.895 of the statutes is created to read:

609.895 Disclosure of charge for clinic services coverage. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.792.

SECTION 9. 632.792 of the statutes is created to read:

632.792 Disclosure of charge for clinic services coverage. (1) DEFINITIONS. In this section:

(a) "Charge for clinic services" has the meaning given in s. 146.97 (1) (a).

(b) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(c) "Self-insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) REQUIRED DISCLOSURE. Every disability insurance policy and every self-insured health plan shall disclose of all of the following in any policy, plan, or certificate of coverage:

(a) Whether the policy or plan covers a charge for clinic services.

(b) The extent of, and limitations on, coverage of a charge for clinic services.

(c) Whether a patient's payment for all or part of a charge for clinic services counts toward satisfying any deductible amount under the policy or plan.

SECTION 10. Initial applicability.

(1) The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.895, and 632.792 of the statutes first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and governmental or school district self-insured health

plans that are established, extended, modified, or renewed, on the effective date of this paragraph.

(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(c) Governmental or school district self-insured health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

SECTION 11. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 120.13 (2) (g), 185.981 (4t), 185.983 (1) (intro.), 609.895, and 632.792 of the statutes and SECTION 10 of this act take effect on January 1, 2011.

(END)

INSERT A

A health care facility or health care provider is not required to make the notification that a charge for clinic services may be imposed if either 1) the health care facility or health care provider provided the notification within the 12 months before the appointment is requested for a health care facility visit for the same services or 2) the health care facility or health care provider previously provided the notification and the patient had a health care facility visit for the same services within the 12 months before the appointment is requested.

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(3) A health care facility or health care provider is not required to provide the notification for an appointment under sub. (2) (a) 1. or 2. if one of the following applies:

(a) Within the 12 months immediately preceding the patient's request for the appointment to receive health care services, the health care facility or health care provider notified the patient under sub. (2) (a) 1. or 2. for a health care facility visit for the same services.

(b) Before the patient requested the appointment to receive health care services, the health care facility or health care provider notified the patient under sub. (2) (a) 1. or 2. for a health care visit to receive the same services, and the patient had a visit for the same services within the 12 months immediately preceding the patient's request for the appointment.

(END)